# Letter from the Program Director

RURAL PREVENTION NETWORK


1-800-371-5020

Dear Colleague:

As a special honoree of the 1996 **Models That Work** competition, I am elated to have the opportunity to share a little information about the Rural Prevention Network and its activities.

Historically, our four county area, tucked away in rural, northern Michigan has had few available prevention services to offer its residents. Primary care providers prove to be too busy with illness treatment, and there are very few other resources available for prevention activity. Thus, the Rural Prevention Network (RPN) was born.

The theory behind the RPN was to pool resources from multiple health agencies in the geographic region of District Health Department No. 2 to provide a stronger, more extensive service base. This collaboration would increase staff power, deliver resources specific to a certain agency to a larger service area, and create new services aimed at chronic disease prevention. Due to an aggressive and creative staff, today's RPN offers an array of services and educational resources to the community and professional population that would not otherwise be possible.

We believe that our project provides an effective way to enhance the health of communities with a limited amount of resources. By involving a variety of individuals from different disciplines, we can reach the appropriate target population with our program services and help people "make healthier choices, easier choices."

Please feel free to contact me after you review this guide. I will be happy to respond to any questions or comments that you have. I believe that the work we have done may be beneficial to those planning similar efforts in other rural areas.

Sincerely,

Lynn Benjamin
Program Director

**Alcona Health Center**
177 N. Barlow Rd.,
Lincoln, MI 48742
Phone (517) 736-8157
Fax (517) 736-8380

**District Health Department No. 2**
630 Progress St.,
West Branch, MI 48661
Phone (800) 371-5020 or
Phone (517) 345-5020
Fax (517) 345-7999

**Healthy Community 2000**
*St. Joseph Health Services of Northeastern Michigan*
200 Hemlock, P.O. Box 659
Tawas City, MI 48764-0649
Phone (800) 362-9404 or
Fax (517) 326-5899

**Sterling Area Health Center**
725 E. State St.,
P.O. Box 740
Sterling, MI 48659
Phone (517) 654-3501
Fax (517) 654-2190

# Introductory Statement

Dear Colleague:

On behalf of the Health Resources and Services Administration
Care and “Models That Work” (MTW) Campaign co-sponsors,
Strategy Transfer Guide. This document is intended to assist y
innovative and creative strategies used by the Rural Prevention
MTW Competition special honorees. This program represents
solution to significant health challenges, developed by building
existing capacities within the community. I encourage you to l
this document.

Although the strategies outlined in this document may be used
no way be interpreted as a step-by-step procedure for solving a
challenges in your community. This document is simply intend
support your efforts in providing effective primary health care s
vulnerable populations.

If you need explanations, advice, or would like additional infor
representative listed in the “Project Overview” or consult the “M
Information” section of this strategy transfer guide.

We hope you find this information useful.

# Project Overview

***Name of Program:*** The Rural Prevention Network

***Lead Organization:*** District Health Dept. #2

***Location:*** West Branch, Michigan

***Annual Budget of Funding Sources:*** $283,614

***Community Need and Target Populations:*** Rural, low-income residents of a medically underserved, four-county area with a high prevalence of chronic disease.

***Primary Care Services Provided:***

- Education
- Screening
- Referral
- Treatment for the most common chronic diseases

***Partner Organizations:*** Two community health centers, a local hospital, and four county Public Health District departments.

***Health Related Outcomes:*** Reduction/elimination of behavioral risk factors associated with chronic disease, thereby reducing chronic disease morbidity/mortality.

***Kind of Model:*** Rural health

***For Additional Information, contact:*** Lynn Benjamin

***Telephone:*** (517) 345-5020
***Facsimile:*** (517) 345-7999

# Project Description

**COMMUNITY RESPONSIVENESS**

Alcona, Iosco, Ogemaw, and Oscoda counties in northeastern Michigan are rural, sparsely-populated, low-income, medically underserved, and heavily burdened with preventable health problems. The larger counties had significantly higher lung cancer death rates than in the United States in 1986 *(Chronic Disease in Michigan)*. In 1992, age-adjusted cancer, heart disease, and chronic obstructive pulmonary disease death rates substantially exceeded those for the State of Michigan. The age-specific death rate among 45-64 year olds was nearly double the State rate, indicating excessive heart disease deaths among working-age individuals *(1992 Michigan Vital Statistics)*. Compounding the problem of chronic disease and high-risk factor prevalence is a shortage of health care providers in the four-county medically underserved area. Medical providers are kept busy with illness care and there are virtually no volunteer health organizations to provide preventive services.

The target population of the Rural Prevention Network (RPN) is the 45-64 year-old, working-age population. The RPN does not deny anyone from participating in or benefiting from RPN services due to age qualifications or inability to pay for services.

The RPN provides a variety of primary and preventive health care services to the residents of the four-county area including smoking cessation and fitness/weight loss programs; nutrition, fitness, healthy heart, and diabetes education; marketing the "Putting Prevention Into Practice" kit; worksite and community health promotion activities supported by the Michigan Department of Public Health; health screenings; referrals for primary care through a toll-free telephone number; health fairs; public service announcements; a quarterly newsletter; and, many other services. These activities are provided specifically to reduce, or eliminate, preventable chronic disease and the behavioral risk factors associated with those diseases.

Community involvement in the RPN design, and implementation of program services, was essential to the success of the initiative. Residents of the four-county area were enlisted to assess the community's needs and interests in terms of primary and preventive health care for chronic disease. The RPN staff then used this information to develop needed services or promote/enhance existing services to meet the needs of the community. Community action committees, comprised of civic minded, pro-community residents, provided the RPN with "behind the scenes" support and advice regarding what preventive and primary health services were most needed and, more importantly, which programs and services would be successful in the community. From the outset, it was clear that partnerships with community organizations would be essential for the success of certain primary and preventive health care services. Examples of collaborative efforts will be mentioned under the community partnerships section of this summary.

As previously mentioned, the residents in the four-county service area of the RPN have several specific barriers affecting their ability to receive adequate primary and preventive care. The residents also have several specific needs relating to the high prevalence of health problems in the four-county area. None of these barriers, or needs, would be considered unique for a specific population or geographi-

cal location, but the fact that the four-county service area of the RPN has so many barriers and health needs makes this service area very unique. The RPN has developed specific policies to offset as many barriers to primary and preventive health care as possible. An example of an RPN policy would be that no individual will be excluded from participation in any RPN service due to an inability to pay for that service.

### INNOVATION

The RPN has several innovative features that make it unique. First, the RPN is composed of four independent health care agencies, with overlapping service areas. For this initiative, they formed a consortium to enhance health care services for the benefit of the entire community. A partnership of this nature has a synergistic effect on health outcomes and greatly enhances the quality of health care services available to community residents. The RPN consortium members disregarded the current trend in health care where individual health care organizations battle each other for every patient and every source of revenue instead of working together as a team to improve the community's health.

The second unique feature of the RPN is the implementation of the dual-directional referral system. This system allows primary care RPN staff for behavioral risk factor reduction services, as well as encourage RPN staff to refer community members to primary care providers for treatment. The system ensures that community members receive behavioral risk factor intervention through increased access to primary and preventive care.

Another important feature is the comprehensive scope of services available to local residents. Components of RPN services include evaluation and demonstration of community interest in receiving convenient and appropriate health care services, development and implementation of cost-effective services, and stimulation and education of existing providers to deliver those services.

The fourth unique feature is the size of the RPN's service area. The service area includes four counties, but residents of bordering counties also have the opportunity to participate in RPN services. The logistical challenges related to serving a large geographical area could be overwhelming if an appropriate mix of staff and services had not been established to ensure that continuity of care was maintained throughout the four-county area.

### COLLABORATION

The RPN consortium is comprised of two nonprofit, federally funded, community health centers; a nonprofit hospital; and the four county health departments. Through the use of Federal funding and the team approach to health care a comprehensive strategy for the prevention of chronic disease was developed. The Federal grant allocated for this project allowed the consortium to hire staff specifically charged with accomplishing RPN goals and objectives. The RPN staff includes five health educators, four volunteer coordinators, and one information/referral specialist. The staff was recruited, hired and then assigned to a specific consortium site. Each staff member is considered an employee of their respective site but, they were hired as an RPN staff member with common goals, responsibilities, and accountability for their share of the RPN service delivery network. The hiring proce-

dure was developed to ensure that each consortium site would receive an RPN staff person and each county would receive the same amount of health care services. The team approach is facilitated through biweekly health educator meetings. These meetings promote collaboration among the health educators, allows for discussion regarding assessment, implementation, and evaluation of current and/or future project objectives.

The health department is the fiduciary agency for the Federal funding allocated to the project, but each consortium member has an equal role in developing and providing services to the community. The equality and collaboration among consortium members is facilitated through an "executive meeting" where RPN staff and the executive directors of each consortium site meet bimonthly to review RPN services, approve budgets, etc. Community organizations actively involved in supporting RPN activities include the local school systems, various local government agencies, local businesses, senior centers, etc.

### SHORT-TERM OUTCOMES

The outcomes of the project have been categorized into short-term and long-term outcomes. Both categories are measurable and represent an assessment of the project objectives which were developed to reach the project goal.

- The evaluation and demonstration of community interest in receiving convenient and appropriate health care services was documented through the use of a community survey. This survey assessed community interest in health care services. And the RPN staff used the information to develop needed services.
- A second outcome relates to convenience and appropriateness of health care services and provider referrals. A detailed tracking system documents referrals from health care providers for RPN services as well as RPN staff referrals to health care providers. The dual-directional referral system indicates how many community members receive primary or preventive care because of the direct efforts of the RPN.
- The project has demonstrated an increase in cost effective, behavioral risk reduction services available to the community by cataloging existing services before project implementation versus cost-effective services available during implementation of the project.
- Staff are currently working with 52 area primary care providers to implement the "Putting Prevention Into Practice" kit. The kit contains material to help primary care providers offer preventive care to their patients. An evaluation process was developed to document the use of the kit by primary care providers and also to evaluate the providers' satisfaction with the material in the kit.

### LONG-TERM OUTCOMES

In conjuction with the Michigan Department of Community Health, a behavioral risk factor survey will be conducted at the end of the project. The results will be compared to the behavioral risk factor survey completed in 1993 by the Michigan Department of Community Health to document measurable health-related outcomes. These project outcomes were made available through a combination of three financial factors: Federal grant funding, consortium in-kind investment, and a

fee-for-service structure. Most project funding is provided through the Federal grant and a project of this size and scope would not be possible without that support.

The fiscal year 1994-95 project documentation indicates that in-kind investment was approximately 45 percent of the total project funding. Examples of in-kind support include office space, printing, travel, executive staff time, and supplies. The last financial factor is fee-for-service. A specific example of a fee-for-service program that demonstrates program success, measurable health-related outcomes, and program costs is the RPN's exercise and weight loss program. This program had 237 participants with a total of 1,875 pounds lost and $5,925 gross revenue from participant fees.

**REPLICATION/SUSTAINABILITY**

This project has the potential of becoming a template for use in any community in the State, or the nation. It can be easily adapted to meet the needs of diverse community populations, or geographic locations. The project goals and objectives could focus on any number of community needs or concerns, which would not necessarily have to involve health care. The project could also be replicated with larger or smaller amounts of funding with a respective change in the level of project objectives and proposed outcomes. The core of the project, collaboration between consortium members, would have to be replicated by other interested organizations in order to successfully administrate and implement a project of this scale and scope of service.

Factors that play a role in project sustainability include the dedication of the organizations involved in the project and their willingness to work as a team; funds available for project use; equitable allocation of funds to consortium members by the fiduciary agency; competency of staff; staff supervisors; staff turnover; and, community support.

The most important factor in the sustainability of a project of this nature is the team of consortium members involved in developing the project, and the day-to-day delivery of project services. The consortium members set the wheels in motion regarding implementation of project objectives. It is essential that these organizations have the same goal in mind and are comfortable working together as a team.

The project is ultimately tied to the available funding because the funding dictates what project objectives will be developed and to a certain extent the eventual outcomes on the community level. It is important for consortium members to obtain as much funding as possible for the project, and it is imperative that the fiduciary agency manage and use the funding appropriately and cost-effectively. Every effort must be made by the fiduciary agency to appropriate funds to consortium members in a fair and impartial manner. Equitable distribution of funds will facilitate trust, respect, and collaboration among consortium members.

The competency of project staff can also be an important component in the sustainability of a successful project. Staff must be organized, self-motivated, comfortable in a variety of community settings, and sufficiently trained in the area of expertise needed to fulfill project objectives. Staff turnover can be

detrimental to continuity of service, so every effort must be made to hire appropriate personnel and provide the necessary support and direction needed to keep project staff professionally fulfilled and satisfied.

The importance of community support in a project of this nature is commonly overlooked, but it should be considered a priority. Community members should and will be involved in advisory roles, collaboration efforts, program and service promotion, etc. If the community does not buy into the project, support the project goals and objectives, and relate to its needs or concerns, the project will not be a success. This project could be replicated in other communities with great success, if the previously mentioned factors that affect sustainability are taken into account.

# Lessons Learned

*The Rural Prevention Network (RPN) staff discuss assessment practices, service delivery, evaluation, and other project objectives during biweekly health educator meetings. RPN targets rural, low-income residents in a medically underserved area of Northern Michigan.*

### ISSUES, PROBLEMS, AND STRATEGIES AT THE OUTSET

District Health Department #2, the fiduciary and lead agency for the Rural Prevention Network (RPN), is rural, sparsely populated, yet heavily burdened with preventable health problems. All four of the District's counties that are now served by the RPN have chronic disease death rates that are significantly greater than the national and State age-adjusted death rates. Compounding the problem of chronic disease and high-risk factor prevalence is a shortage of health care providers in the district. Part, or all, of every county in the District is either a health profession shortage area, medically underserved, or both.

The physicians, especially primary care providers, are so busy with illness care that they lack the resources and time to provide appropriate individual preventive services. Also, there are virtually no volunteer health organizations to provide prevention services.

### INITIAL RESPONSE TO THE PROBLEM

No one health care agency could solve these problems alone. It required collaboration among all of the major health care players in the District.

In a large geographic region, each hospital and/or health care agency services the community almost in isolation. Each agency also had limited staff to provide education and counseling, which made it difficult to work together and share resources.

Funding to enhance staff capacity and increase networking was imperative, as well as delivery systems to support the efforts of local health professionals. A major initiative was to market the "Putting Prevention Into Practice" kit to primary care physicians. It was also important to educate key community groups

*Lynne Benjamin is the program director of the Rural Prevention Network. This innovative program pools resources from multiple health agencies to deliver much-needed services to rural, low income residents.*

and obtain their input regarding the existing health care situation.

To obtain feedback from patients, and other consumers, RPN placed health and interest survey forms in the offices of local physicians, hospitals, and health centers.

In addition, we increased the number of clinical preventive services provided both at the primary care site and RPN sites. These services included heart health screening such as cholesterol, blood pressure screenings, diabetic assessments, etc. A toll-free information and referral service directs individuals to the appropriate RPN consortium site or service, then mails prevention materials to callers.

### OUR PHILOSOPHY FOR SERVICE DELIVERY

Countering the repeated pattern of the working age (45-64 year old) individuals dying too young from preventable disease.

### QUALITATIVE AND QUANTITATIVE PROGRAM OUTCOMES

The qualitative outcomes were achieved by implementing some social marketing strategies, such as providing every physician with a TV-VCR unit and a video that plays chronic disease prevention messages in waiting areas. This prevention strategy ties in well with marketing the "Putting Prevention Into Practice" kits that encourage physicians to inquire into the patients' clinical preventive service status.

The RPN also sponsors a national health observance each month as part of a social marketing effort. Every week, prevention focused interviews are aired with a community expert (physician, dietician, or other health care professional). The RPN created a "Tune in for a Healthier Life" brochure to promote the radio program which includes coupons that reinforce healthier lifestyle choices ($10 discount on nicotine patches, free ski rentals, special prices on bananas and apples, and Heartwise restaurant selections). It not only markets RPN services but promotes the monthly prevention focus that collaboratively each site is responsible for coordinating.

In addition, every site is responsible for submitting a press release, radio messages with health trivia questions, and recording a prevention focus interview on that specific month's National Health Observance focus. A radio station is contracted to play ads, promote health trivia contests and RPN healthy coupons as part of the social marketing plan written into the grant. This brochure is

distributed to physician offices, RPN sites, and coupon vendors.

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### EFFECTIVE CONSENSUS BUILDING STRATEGIES FOR CONFLICT RESOLUTION BETWEEN PARTNERS

The executive community realized that it would take time for this project to become a known entity within the existing health care service delivery systems. This meant that in order to create an identity for the RPN, an unselfish approach to marketing would need to be put into place. Marketing the RPN as a network, instead of separate agencies that might threaten each other's autonomy, had to be considered. A flyer was produced that listed each service network site and specific address and phone number for additional programs and services that individual sites might provide.

### OVERCOMING BARRIERS, LEVERAGING PARTNER RELATIONSHIPS AND BUILDING ALLIANCES FOR SUCCESS

Partner relationships were actually established when the initial proposal was written to obtain funds. We determined what each member would contribute based on current staff and the resource capacities.

Another important factor was obtaining cooperation from the already overwhelmed physicians to incorporate the "Putting Prevention Into Practice" kit materials into their office routine. At first it was extremely difficult to get them to find time for our visits. But, by involving them in project activities over the last two years we have received their support. We developed a newsletter that includes physician quotes and pictures, as well as a new marketing campaign that gives physicians an opportunity to record a prevention message with a local radio station. In fact, many physicians are now requesting refills of the "Putting Prevention Into Practice" kit for their office.

Another stumbling block was to make sure consumers were able to participate in our prevention activities. Transportation and day care needs were addressed and the health and interest surveys we designed have been instrumental in developing services that reduced barriers to care.

# Implementation of Model Program/System

### GETTING STARTED

- *Consortium roles and responsibilities were addressed and included in the initial grant application.* It was agreed that each consortium site would obtain a contractual employee to carry out project activities. An Executive Committee was formed to oversee the project and make decisions such as staffing structure, budget modifications, major policies, and programmatic development.

- *Staff recruitment.* A health educator was hired at each site to carry out project objectives and evaluation components. All staff have received computer training either through on-the-job experience, or a professional consultant was retained to conduct training workshops at the health department.

  The site coordinators developed timetables and staff assignments to assist new staff with their responsibilities and narrow the scope of activities. Site coordinators oversee project staff and activities.

  Developing the initial work template was arduous, but a spreadsheet of specific daily-to-weekly activities was developed to assist in coordinating service delivery systems. These assignments included cataloguing existing preventive services and primary care providers; reviewing grants and the *Guide to Clinical Preventive Service*, which along with the "Putting Prevention Into Practice" kit was a major strategy to market physicians.

  From the beginning, health education staff scheduled biweekly meetings to plan activities and share ideas and resources. The executive members met immediately following the health education staff in order to oversee project status.

- *Community stakeholder involvement initiated at the onset of grant award.* Formal presentations were made at each county's Human Service Coordinating Council. These coordinating bodies are made up of health and human service agency directors and mid-level management. These presentations not only described the purpose of the RPN but enlisted informal support of participatory bodies throughout the project duration.

### FUTURE GROWTH AND SUSTAINABILITY

As with any project whose sole revenue is driven by cost-effective (ability to pay) prevention programs, becoming self-sufficient is not likely. The limited revenue does help support the promotion of available services; however, if continual funding is not sought through Federal, State, and local monies, the RPN today as we know it will be greatly reduced in scope. Even though the main focus for the first three years of the project was chronic disease, there is a potential for many other funded prevention pieces. Obviously, Federal funding made the RPN possible at first, but no matter if funding is there or not, a strong sense of commitment to solving service gaps and health problems together has been established and will continue to carry on.

# Funding/Resource Development

The Rural Prevention Network (RPN) works together to make "healthier choices easier choices" in northeast Michigan. The RPN promotes chronic disease prevention through greater community awareness, health education, and increased availability of preventive services.

AHC alcona health center

A federally qualified community health center providing comprehensive primary health care to Alcona county and surrounding areas.

**DISTRICT HEALTH DEPARTMENT NO. 2**

A full service public health agency providing health promotion, disease prevention, and environmental health services for all individuals in the counties of Alcona, Iosco, Ogemaw, and Oscoda.

Sterling Area Health Center

A federally qualified community health center providing comprehensive primary health care to Arenac, Ogemaw, and surrounding counties.


St. Joseph Health System provides a value based, integrated health delivery system to the communities we serve.

# Models That Work Campaign Information

The Health Resources and Services Administration's Bureau of Primary Health Care, in collaboration with 39 co-sponsoring foundations, associations, and nonprofit organizations, has identified winners and special honorees in the 1996 **Models That Work** Campaign. To obtain strategy transfer guides for the programs listed below, contract the National Clearinghouse for Primary Care Information (NCPCI) at (800) 400-2742.

**1996 Winners**

| PROGRAM NAME | KIND OF PROGRAM |
|---|---|
| Abbottsford and Schulykill Falls Community Health Centers | Nurse-Managed Community Health Center |
| Camp Health Aide Program (CHAP) | Culturally-Attuned Community Outreach |
| Comprehensive Community Health Services Program of Project Vida | Integrated Family Health and Social Services |
| Hillsborough County Health Care Plan | Countywide Managed Care for Indig Residents |
| The Los Angeles Free Clinic Hollywood Center | Peer Outreach and Access for High- Youth |

**1996 SPECIAL HONOREES**

| PROGRAM NAME | PROGRAM CATEGORY |
|---|---|
| Accomack County School-Based Dental Program | Oral Health |
| Chicago Health Corps | Health Professions Program Particip |
| Children's FACES (Family AIDS Clinic and Educational Services) | HIV/AIDS |
| Growing Into Life Task Force | Maternal and Child Health |
| Independent Care | Managed Care |
| Marion County Child Health Initiative | City- or County-Level Coordination |
| MOM's Project | Substance Abuse Prevention and Treatment |
| Rotacare Free Clinics | Business Participation |
| The Rural Prevention Network | Rural Health |

In addition to the **Models That Work** video (available April 1997) and other resource materials, the Bureau of Primary health Care has published the 1996 **Models That Work** Compendium. This publication describes unique features of more than 275 community-based primary health care programs that participated in the 1996 competition. To obtain a copy of the compendium, video, or other materials, call (800) 400-2742. (Residents of the Washington, DC, metropolitan area, dial 703-821-8955, extension 248.)

**National Clearinghouse for Primary Care Information (NCPCI)**
2070 Chain Bridge Road
Suite 450
Vienna, Virginia 22182
Telephone: 800-400-2742
Facsimile: 703-821-2098
E-mail: primarycare@circsol.com

For additional information about the **Models That Work** Campaign, or if you have questions or suggestions, contact:

**Models That Work Campaign**
Coordinator
Bureau of Primary Health Care
4350 East-West Highway, 7th Floor
Bethesda, Maryland 20814
Telephone: 301-594-4334
Facsimile: 301-594-4983/4997
E-mail: models@hrsa.dhhs.gov>
Homepage: http://www.bphc.hrsa.dhhs.gov/mtw/mtw.htm

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This Strategy Transfer Guide is made possible through the "Models That Work" Campaign, sponsored by the Health Resources and Services Administration's (HRSA) Bureau of Primary Health Care. We would like to acknowledge and thank our contributing co-sponsors listed below:

American Academy of Physician Assistants

American Clinical Laboratories Association

Catholic Health Association of the United States

HRSA, Maternal and Child Health Bureau

HRSA, Office of Rural Health Policy

National Association of Community Health Centers

National Organization of AHEC Program Directors

National Rural Health Association

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